MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF FAMILY AND COMMUNITY HEALTH

COMMUNITY PUBLIC HEALTH OTOLOGY CLINIC
PAYMENT VOUCHER WORKSHEET

I. PURPOSE:
The information below is needed to provide payment for professional services. Professional services were performed at the community health otology clinic held by _____ Health Department on _____ 200____ in _____ (City) for _____ County.

II. PROFESSIONAL INFORMATION:
Type of Services: AUDIOLOGIST _____ PHYSICIAN _____

NAME _____ (Type or print) Signature _____ (Original signature)
Send payment to:

_____
_____

If payment is to go to the contractor's business, use Federal ID#:, if payment is to an individual, use Social Security #. **(DO NOT USE BOTH)**

_____ FED. I.D. #: _____

_____ SOC. SEC. #: _____
(City) (State) (Zip Code)

CONTACT BUSINESS PHONE NUMBER (FOR PAYMENT QUESTIONS) _____

Complete the items below if travel subsistence is requested. Reimbursement cannot exceed current State Standardized Travel Regulations.

MILES TRAVELED TO/FROM CLINIC (ROUNDTRIP) _____

LUNCH (full day clinics only) $ _____ LODGING $ _____

III. CLINIC INFORMATION:

TIME CLINIC STARTED _____ TIME CLINIC ENDED _____

NUMBER OF CHILDREN SEEN BY THE PROFESSIONAL DESIGNATED IN SECTION II ABOVE

_____

SIGNATURE _____ (Hearing Program Coordinator/Supervisor - LHD) DATE _____

Note: This form must be completed separately and accompanied by Form DCH-0526 (H-628) for audiology and physician services to be reimbursed.

M D C H U S E O N L Y
(Use of this form is required for payment)

Miles_____ X _____ = Mileage $_____ Professional Services $_____ Meals $_____ Lodging $ _____

TOTAL VOUCHER AMOUNT $ _____